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MassHealth Payment and Care Delivery Reform

Executive Office of Health & Human Services

Presentation to the PWTF Sustainability Committee

December 10, 2015

Restructuring MassHealth: principles of our approach

Person-centered	Concentrate on improving quality and member experience
Clinically appropriate	Ensure clinically sound design through direct input from Massachusetts members and providers
Appropriate for all	Account for varied member populations and providers (i.e., not a one-size-fits-all model)
Pragmatic	Identify realistic solutions that can be implemented in a practical and timely manner
Fact-based	Make design decisions based on facts and data
Financially Sustainable	Ensure improvements lead to a more cost effective and sustainable system

What we heard

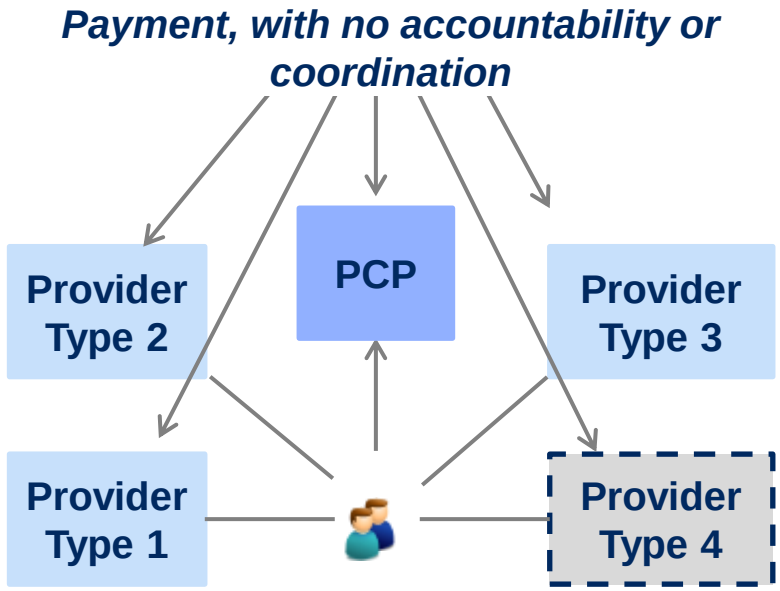
- Members are often **not in charge of or engaged in their care**
- Providers are often working in silos and lacking incentives to **create integrated care experience** for members
- **Payment model** is not aligned for improving quality/cost, and investing in integration of care

What we plan to do

- Move to a **sensible care delivery and payment structure** where:
  - We pay for **value, not volume**
  - Members drive their **care plan**
  - Providers are encouraged to **partner in new ways** across the care continuum to **break down existing siloes** across physical, BH and LTSS care
  - **Community expertise** is respected and leveraged
  - Cost growth and avoidable utilization are **reduced**

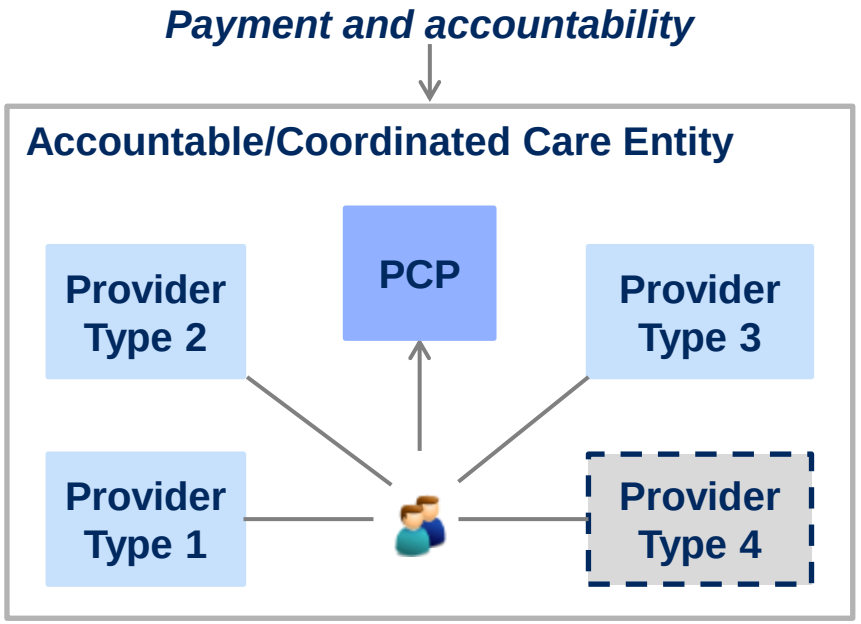
In practice, this is what integrating care will look like

The current system



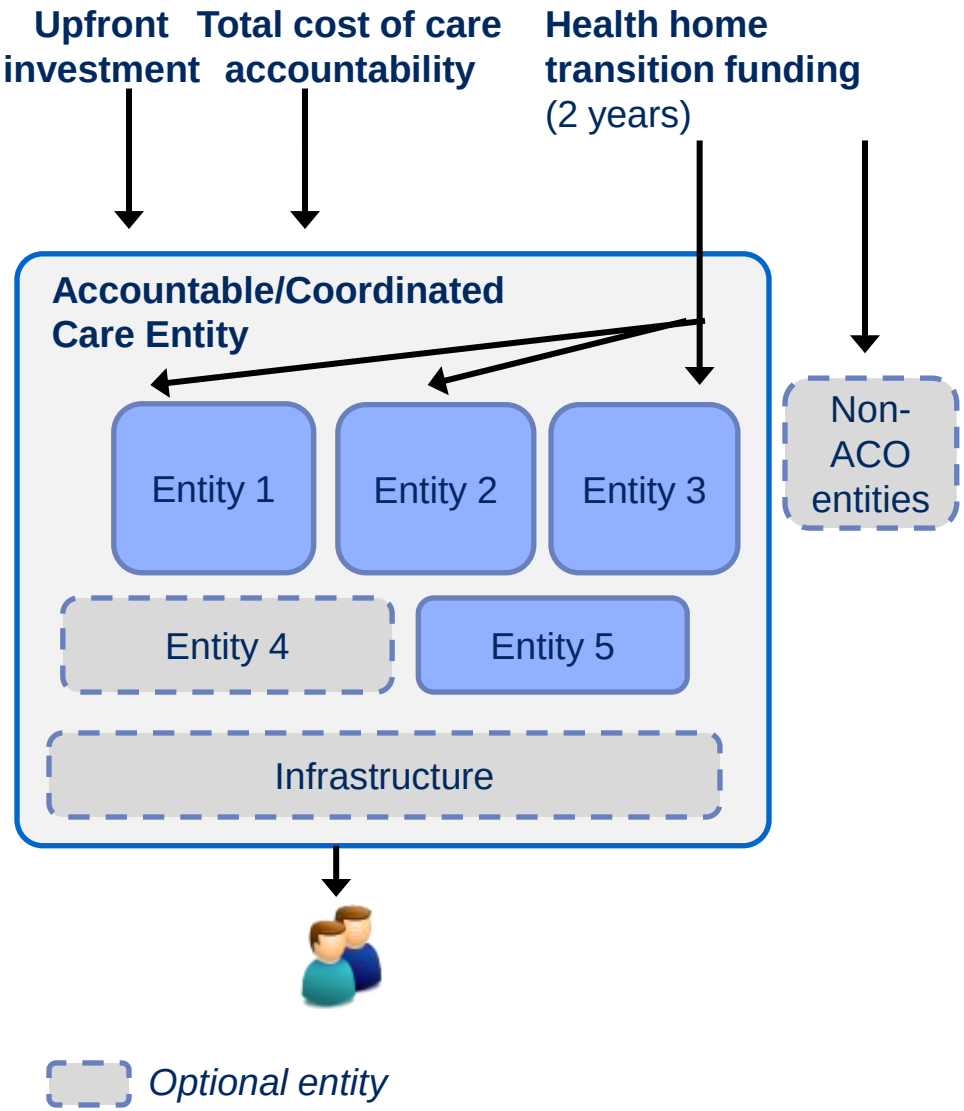
- Members are at the center of **complex networks of care**
- Each provider in the network is **paid separately**, with no requirement to coordinate with the others
- No single person or entity is **accountable** for ensuring an **integrated, member-driven experience**

Integrated, accountable care



- Members are still at the center of complex networks of care
- Payment and accountability goes to a **single entity** (e.g., ACO) that contracts with MassHealth to provide **integration, coordination, and cost accountability** for the providers and members it serves

Payment and Care Delivery Reform – starting point for workgroups



- **Partnerships** across the care continuum
- **Explicit goals** on reducing avoidable utilization (e.g., avoidable ED visits) and increasing primary, BH, and community-based care;
- A feasible and **financially sustainable transition** for provider partnerships that commit to accountable care
- **A statewide Health Homes program** to deliver care management and coordination services to appropriate populations of members with eligible chronic conditions
- **Explicit incorporation of social determinants of health**, through the technical details of the payment model and in care delivery requirements;
- Valuing and explicitly incorporating the **member experience and outcomes**

Payment and Care Delivery Reform – starting point for workgroups

- MassHealth is exploring linking payment and care delivery reform strategies with Massachusetts' conversations with CMS about the **1115 waiver**

- **State commits to annual targets for performance improvement over 5 years, e.g.,**
  - Reduction in total cost of care trend
  - Reduction in avoidable utilization (e.g., avoidable admissions)
  - Improvement in quality metrics

- **Make case to receive federal investment upfront through waiver**
  - Seek upfront CMS investment in new care delivery models
  - State at risk for meeting performance targets
  - Creates access to new funding to support transition and system restructuring

- **Access to new funding contingent on providers partnering to better integrate care**
  - ACO-like model with greater focus on delivery system integration
  - Total cost of care accountability

Key design questions (discussed across all workgroups)

1. **Goals and outcomes** the Commonwealth aspire to achieve in the next 5 years through payment and care delivery reform efforts
2. **Member populations** to be included in ACO models; **timing/sequencing** of implementation
3. **Number and types of ACO models** MassHealth should launch
   - Minimum requirements and requirements for Behavioral Health and LTSS populations
   - Payment model requirements
4. **Configurations for partnerships across the care continuum**
   - "Buy *vs.* build" incentives
   - Support for BH/LTSS and CBO infrastructure
   - Management Services Organization (MSO) services
5. **How ACO model interacts and interrelates with other programs**
   - ACO and MCO
   - ACO and SCO, One Care, PACE
   - ACO and LTSS
6. **Member engagement goals, member protections and member choice**
   - Ability to select into ACO
   - Ability to opt-out
   - Network requirements
7. **Strategies to incorporate social determinants of health into the models**
8. **Care coordination expectations and models**
9. **Timing and sequencing of various procurements**

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10. ***CMS waiver discussions, statewide targets on cost, quality, access and member experience***

Creating a strawman framework that answers these questions will then inform further on technical details of payment model

Reform under consideration: Current thinking for eligible populations

- **Starting point: Medicaid-only population**, including those with LTSS needs, **included in MassHealth ACO models**
  - MassHealth spend only
  - Non-dual HCBS Waiver populations eligible, ACO budgets will not include waiver services
  - Future discussions on how to bring value-based contracting expectations to SCO/One Care models

- ACOs will be **financially accountable** for physical health, BH, and pharmacy (with adjustments for price inflation) starting in year 1

- We will transition financial accountability for **MassHealth state plan LTSS costs over time**, starting year 2 to allow for:
  - Establishing strong partnerships between ACOs and LTSS providers
  - Developing solid measurement strategy for quality and member experience
  - Discussions with CMS and approvals

- ACOs will have broad responsibility to integrate care across all these disciplines and to integrate **social services and community supports**

- Quality/ member experience metrics core part of **ACO and state accountability**

- This is a **starting point** and we will explore ways to further increase coordination and expand integrated and accountable care to other populations over time, including duals

ACO Payment Models: Three Models under Consideration

- **Model 1: Retrospective ACO model**
  - Individual providers paid fee-for-service throughout the year
  - ACO has total cost of care/ quality accountability and periodically receives a retrospective reconciliation compared to a risk-adjusted budget
  - Various options for member attribution (based on claims, or through PCP selection)
  - Insurance risk bounded through various arrangements

- **Model 2: Prospective ACO/MCO model**:
  - Integrated ACO/MCO model
  - Attributes members through active selection/enrollment into the ACO
  - ACOs receive up-front, prospective payments, manage a provider network and pay claims for their attributed members (like MCOs)

- **Model 3: Prospective ACO model**:
  - Pricing model focused on performance vs. insurance risk
  - Member attributed through active selection/enrollment into the ACO
  - Need to further explore feasibility

- Minimum case volume applies across aggregate MassHealth volume (PCC/MCOs)

Additional Considerations
- All models subject to feasibility and CMS approval
- ACO and MCO procurement will be aligned to ensure operational simplicity across models

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Appendix

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Context on DSRIP Investment Model and CMS Expectations

What is Delivery System Reform Incentive Program (DSRIP)?

- Waiver program in which providers can receive time-limited federal investment to catalyze delivery system improvement
- Funding at risk and tied to performance metrics
- Several states have received significant new federal funding under DSRIP waivers, to catalyze/accelerate care delivery reform or implement new payment models
- Going forward, significant number of other states "competing" for funding; process will be more structured than states receiving earlier investments (OR, NY)

Expectations from CMS

- State commitment to concrete and measurable improvement targets on cost, quality, and member experience
- Implementation of and broad participation in alternative payment models (APMs)
- Meaningful delivery system reform, including provider partnerships across the care continuum
- Confidence in state ability to execute successfully